

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-001634

246

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002 Registrar's No.

FILED JAN 28 1963

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY JOHNSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 1 WEEK	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION TRINITY LUTHERAN HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM HARVEY HENSLEY, Sr.		4. DATE OF DEATH Month Day Year JANUARY 12 1963	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/7/1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LIVESTOCK SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY KANSAS CITY STOCKYARDS	
11. BIRTHPLACE (City and state or country) AMORET, MISSOURI		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME JOHN T. HENSLEY		13b. MOTHER'S MAIDEN NAME MAMIE BOONE O'REAR	
14. NAME OF HUSBAND OR WIFE MRS. KATHERINE HENSLEY		Address 5104 GRANADA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT KATHERINE HENSLEY, ROELAND PARK, KAS.		Address 5104 GRANADA	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute perforative appendicitis</i>		INTERVAL BETWEEN ONSET AND DEATH 8 days -	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>arteriosclerotic Cardiovascular disease</i>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>April 21, 1963</i> to <i>Jan. 12, 1963</i> and last saw him alive on <i>Jan 11, 1963</i> Death occurred at <i>1:30 P. M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Jay J. Carduff		22b. ADDRESS <i>6300 Glenwood Shawnee, Kansas</i>	
22c. DATE SIGNED 1-12-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JAN. 15, 1963	23c. NAME OF CEMETERY OR CREMATORIUM MT. MORIAH CEMETERY	
23d. LOCATION (City, town, or county) KANSAS CITY MISSOURI			
24. FUNERAL DIRECTOR ADDRESS D.W. NEWCOMER'S SONS, KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. 1-15-63	
26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>			

USE BLACK INK  
OR  
TYPEWRITER RIBBON

RECEIVED JUNE 10 1966

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Dean W. Huff*

Licensed Embalmer No.

*4914*

P. O. Address

*Indep., Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.

*Dr. Jay L. Caudill  
1380 W. Levensworth (1/2) Highway 50 - across from Fairview 1166*